Reprinted
January 25, 2005

SENATE BILL No. 222

DIGEST OF SB 222 (Updated January 24, 2005 2:39 pm - DI 104)

Citations Affected: IC 27-8; noncode.

Synopsis: Preexisting condition waivers. Provides that individual and certain group policies of accident and sickness insurance may contain a waiver of coverage for a specified condition under certain circumstances. Specifies that an offer of coverage under a policy that includes a waiver does not preclude eligibility for a comprehensive health insurance association policy. Requires reporting by insurers to the department of insurance. Requires the department of insurance to submit a report to the legislative council.

Effective: July 1, 2005.

Miller, Paul, Riegsecker

January 4, 2005, read first time and referred to Committee on Health and Provider Services.
January 13, 2005, amended, reported favorably — Do Pass.
January 24, 2005, read second time, amended, ordered engrossed.

Reprinted
January 25, 2005

First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

SENATE BILL No. 222

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-5-2.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.7. (a) Notwithstanding section 2.5 of this chapter, an individual policy of accident and sickness insurance may contain a waiver of coverage for a specified condition and complications that arise from the specified condition if:**

(1) the waiver period does not exceed five (5) years; and

(2) all the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.

(B) The:

(i) offer of coverage; and

(ii) policy;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and treatment for which coverage is waived.

(C) The:

(i) offer of coverage; and

(ii) policy;

do not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) The waiver of coverage does not apply to coverage required under state law.

(H) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(b) An insurer may not, on the basis of a waiver contained in a policy as provided in subsection (a), deny coverage for any condition, complication, service, or treatment that is not specified as required in the:

(1) written notice under subsection (a)(2)(A); and

(2) offer of coverage and policy under subsection (a)(2)(B).

(c) An individual who is covered under a policy that includes a waiver under subsection (a) may directly appeal a denial of

coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.

(d) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(e) Upon the expiration of the waiver period allowed under this section, the insurer:

(1) shall remove the waiver;

(2) shall not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and

(3) shall renew the policy in accordance with 45 CFR 148.122.

SECTION 2. IC 27-8-5-19.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 19.3. (a) This section applies to an association or a discretionary group policy of accident and sickness insurance:**

(1) under which a certificate of coverage is issued after June 30, 2005, to an individual member of the association or discretionary group;

(2) under which a member of the association or discretionary group is individually underwritten; and

(3) that is not employer based.

(b) Notwithstanding sections 19 and 19.2 of this chapter, a policy described in subsection (a) may contain a waiver of coverage for a specified condition and complications that arise from the specified condition if:

(1) the waiver period does not exceed five (5) years; and

(2) all the following conditions are met:

(A) The insurer provides to the applicant before issuance of the certificate a written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.

(B) The:

(i) offer of coverage; and

(ii) certificate of coverage;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each

related condition, complication, service, and treatment for which coverage is waived.

(C) The:

(i) offer of coverage; and

(ii) certificate of coverage;

do not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage, and any individual to whom the waiver would have applied may apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) The waiver of coverage does not apply to coverage required under state law.

(H) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

(c) The insurer shall require an applicant to initial the written notice provided under subsection (b)(2)(A) and the waiver included in the offer of coverage and in the certificate of coverage under subsection (b)(2)(B) to acknowledge acceptance of the waiver of coverage.

(d) An insurer may not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition, complication, service, or treatment that is not specified as required in the:

(1) written notice under subsection (b)(2)(A); and

(2) offer of coverage and certificate of coverage under subsection (b)(2)(B).

(e) An individual who is covered under a policy that includes a waiver under this section may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.

(f) An offer of coverage under a policy that includes a waiver

under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(g) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(h) Upon the expiration of the waiver period allowed under this section, the insurer:

(1) shall remove the waiver;

(2) shall not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and

(3) shall renew the policy in accordance with 45 CFR 148.122.

SECTION 3. IC 27-8-10-5.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 5.1. (a) A person is not eligible for an association policy if the person is eligible for Medicaid. A person other than a federally eligible individual may not apply for an association policy unless the person has applied for Medicaid not more than sixty (60) days before applying for the association policy.

(b) Except as provided in subsection (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. However, an offer of coverage described in IC 27-8-5-2.5(e), ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2(e), **or IC 27-8-5-19.3** does not affect an individual's eligibility for an association policy under this subsection. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(c) Except as provided in IC 27-13-16-4 and subsection (a), a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of

age from eligibility for an association policy.

(d) Coverage under an association policy terminates as follows:

(1) On the first date on which an insured is no longer a resident of Indiana.

(2) On the date on which an insured requests cancellation of the association policy.

(3) On the date of the death of an insured.

(4) At the end of the policy period for which the premium has been paid.

(5) On the first date on which the insured no longer meets the eligibility requirements under this section.

(e) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(f) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(g) Except as provided in subsection (h), an association policy may contain provisions under which coverage is excluded during a period

of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (c), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(i) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 4. IC 27-8-29-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:

(1) grievance filed under IC 27-8-28; or

(2) denial of coverage based on a waiver described in IC 27-8-5-2.5, ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2, **or IC 27-8-5-19.3.**

SECTION 5. IC 27-8-29-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

(1) an adverse determination of appropriateness;

(2) an adverse determination of medical necessity;

(3) a determination that a proposed service is experimental or investigational; or

(4) a denial of coverage based on a waiver described in IC 27-8-5-2.5, ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2, **or IC 27-8-5-19.3;**

made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

SECTION 6. IC 27-8-29-13 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's:

(A) appeal resolution under IC 27-8-28-17; or

(B) denial of coverage based on a waiver described in IC 27-8-5-2.5, ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2, **or IC 27-8-5-19.3;**

not more than forty-five (45) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

(6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.

SECTION 7. IC 27-8-29-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 15. (a) An independent review organization shall:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within three (3) business days after the external grievance is filed; or

(2) for a standard appeal filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and

(2) the terms of the covered individual's accident and sickness insurance policy.

(c) In an external grievance described in section 12(4) of this chapter, the insurer bears the burden of proving that the insurer properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5, ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2, **or**

IC 27-8-5-19.3.

(d) The independent review organization shall notify the insurer and the covered individual of the determination made under this section:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; and

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

SECTION 8. [EFFECTIVE JULY 1, 2005] **IC 27-8-5-2.7, as added by this act, applies to a policy of accident and sickness insurance that is issued or delivered after June 30, 2005.**

SECTION 9. [EFFECTIVE JULY 1, 2005] **(a) An insurer that issues a policy of accident and sickness insurance that contains a waiver under IC 27-8-5-2.7 or IC 27-8-5-19.3, both as added by this act, shall submit to the commissioner of the department of insurance the following information for the reporting periods specified under subsection (b) on a form prescribed by the commissioner:**

(1) The number of policies and certificates that the insurer issued with a waiver.

(2) A list of specified conditions that the insurer waived.

(3) The number of waivers issued for each specified condition listed under subdivision (2).

(4) The number of waivers issued categorized by the period of time for which coverage of a specified condition was waived.

(5) The number of applicants who were denied insurance coverage by the insurer because of a specified condition.

(b) An insurer shall submit to the commissioner of the department of insurance the information required under subsection (a) as follows:

(1) Not later than September 1, 2006, for the reporting period July 1, 2005, through June 30, 2006.

(2) Not later than September 1, 2007, for the reporting period July 1, 2006, through June 30, 2007.

(c) The commissioner of the department of insurance shall forward the information submitted:

(1) under subsection (b)(1) not later than November 1, 2006; and

(2) under subsection (b)(2) not later than November 1, 2007;

to the legislative council in an electronic format under IC 5-14-6.

(d) The commissioner of the department of insurance shall

compile the information submitted under subsection (b) and, not later than November 1, 2007, report the information to the legislative council in an electronic format under IC 5-14-6.

(e) This SECTION expires June 30, 2008.

SENATE MOTION

Madam President: I move that Senator Paul be added as second author of Senate Bill 222.

MILLER

SENATE MOTION

Madam President: I move that Senator Riegsecker be added as coauthor of Senate Bill 222.

MILLER

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 222, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 3, delete lines 5 through 7.

Page 4, delete lines 40 through 42.

and when so amended that said bill do pass.

(Reference is to SB 222 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 2.

SENATE MOTION

Madam President: I move that Senate Bill 222 be amended to read as follows:

Page 1, line 7, after "(1) the" insert "**waiver**".

Page 1, line 7, delete "for which the exemption would be in effect".

Page 3, between lines 4 and 5, begin a new paragraph and insert:

"**(d) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.**

(e) Upon the expiration of the waiver period allowed under this section, the insurer:

(1) shall remove the waiver;

(2) shall not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and

(3) shall renew the policy in accordance with 45 CFR 148.122.".

Page 3, line 19, after "(1) the" insert "**waiver**".

Page 3, line 19, delete "for which the exemption would be in effect".

Page 4, between lines 36 and 37, begin a new paragraph and insert:

"**(g) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.**

(h) Upon the expiration of the waiver period allowed under this section, the insurer:

(1) shall remove the waiver;

(2) shall not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and

(3) shall renew the policy in accordance with 45 CFR 148.122.".

(Reference is to SB 222 as printed January 14, 2005.)

MILLER